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Health Research, Qualitative

Qualitative health research is social research that uses qualitative methods to study problems in health, illness, and medicine. These methods include participant observation, in-depth interviewing, document analysis, and focus groups. The data collected are qualitative in nature including fieldnotes, open-ended interviews, narratives, text, organizational documents, and news and media excerpts. The data are usually in text form, but also may be visual or pictorial, and are analyzed by a variety of strategies (see Miles and Huberman 1994, Strauss 1987).

Qualitative health research is distinguished from quantitative and clinical research. Quantitative health research typically utilizes some kind of numerical data (e.g., from censuses, surveys, or experiments) and relies on statistical techniques for analysis. Clinical research is usually based on patient populations and is conducted as an adjunct to the delivery of medical care, focusing on clinical (e.g., treatment) problems. Some clinical research may use qualitative data, but typically qualitative health research does not focus on clinical or medically defined problems.

1. Background and Context

The roots of modern qualitative research can be found in early twentieth century social science (Vidich and Lyman 1994). While anthropologists had used ethnographic field work to study nonliterate and tribal cultures, sociologists at the University of Chicago in the 1920s pioneered using participant observation studies for examining aspects of urban and industrial societies (Bulmer 1984). Very little of this early fieldwork focused on health or medicine, although the classic study of *Middletown* did devote a chapter to it (Lynd and Lynd [1929] 1956).

During the 1950s and 1960s a new generation of University of Chicago trained sociologists including Everett Hughes, Anselm Strauss, Howard S. Becker, Eliot Freidson, Julius Roth, and Fred Davis, among others, laid the groundwork for the modern development of qualitative health research (Charmaz and Olesen 1997). This research was characterized by ethnographic approaches and the use of qualitative data, especially from interviews and observation, focusing on the subjective and interactional aspects of social life.

Early studies focused on medical education, organization of health care, medical institutions (especially hospitals), doctor–patient interaction, and death and dying. Several of these studies, especially by Becker et al. (1961) and Glaser and Strauss (1967) contributed significantly to the development of more rigorous and systematic data gathering and analytic methods.

Others like Goffman's (1961) *Asylums* became classics in the field.

In the latter years of the twentieth century qualitative health research prospered and continued to evolve. While social scientific research on health and medicine was dominated by quantitative studies, qualitative studies first found an intellectual niche and later flourished.

While sociologists pioneered qualitative health research, other disciplines adapted it to their own research needs. Anthropologists, who had long used qualitative methods, began to focus more research on modern societies and conducted studies on ethnicity, illness, and health care in community settings (Good and Good 2000). Qualitative studies permeated nursing research, in part because of the development of a nursing Ph.D. program at the University of California, San Francisco by Anselm Strauss and his colleagues. Feminist researchers have used qualitative methods for research on gender and health, reproductive issues, care-giving and care-receiving (Olesen 1994). Beginning in the late 1960s, British academics adopted qualitative methods to conduct research in health and medicine. In ensuing years it was adopted by researchers in France, Australia, Germany and other countries (Anderson and Bury 1988).

Qualitative methods are now well established in social scientific health research. Any number of useful primers for qualitative research now exist (e.g., Lofland and Lofland 1995), as well as compendiums for more advanced researchers (e.g., Denzin and Lincoln 1994, Hammersley and Atkinson 1995). Several journals feature qualitative studies, especially *Sociology of Health and Illness*, *Medical Anthropology Quarterly*, *Health*, and *Qualitative Health Research*. Dozens of health-related books based on qualitative data from researchers in several fields appear each year.

2. Types of Qualitative Methods

2.1 Participant Observation

Participant observation is the classic form of qualitative research. In this mode, the researchers collect observational data by observation in a situation or organization, after gaining access to their research sites. The balance between participation and observation varies, depending on the researcher and the site. The goal of the research is to understand the situation from the perspective of the participants and gaining this type of social scientific empathy can be a lengthy process. Participant-observers take fieldnotes based on their observations, which become the core data and the basis of their analysis and report. Observation is often combined with informal and formal in-depth interviewing to broaden data sources.

Participant observation is very labor- and time-intensive, but allows a close-up view of social life. In health research it has been used with great benefit for

the study of medical education (Becker et al. 1961), the delivery of health care (Zussman 1992), uses of medical technology (Timmermans 1999), professional-patient interaction (Waitzkin 1991), patient and self-help groups, alternative health care, and interaction among professionals (Bosk 1979).

2.2 In-depth Interviewing

In-depth interviewing is a central method of qualitative data collection, characterized by the researcher asking respondents a series of open-ended questions or raising topics for discussion. This is contrasted to survey interviewing, where researchers use mostly fixed-response questions (e.g., yes or no, multiple choice, Likert scale questions). Many researchers see in-depth interviewing as a 'guided conversation,' lasting perhaps from 15 minutes to many hours. While some use a fixed list of questions, others prefer to have an interview guide of topics, and then allow respondents to present their view or 'tell their story.' In either case, the goal here is to obtain narrative or textual data in the respondent's own words. Some studies are longitudinal and conduct several interviews with the same subjects of a period of time. Researchers often use tape recorders or similar devices and then transcribe the tapes into written textual data.

Researchers need to be careful to construct their interview guides so as not to unnecessarily bias the data. Questions should be asked in as neutral a form as possible and interviews should take place in a situation that is comfortable for the researcher and the respondent. One of the benefits of this kind of interviewing is that it allows the researcher to be sensitive to respondents and adjust the interview to new paths in the research inquiry.

The number of respondents in such studies varies greatly. Some studies use just a few selected respondents and interview them in great detail and depth. At the other end of the spectrum, some studies use a randomly selected sample of hundreds of respondents, each of whom is interviewed (in this case, usually by members of a research team). Most frequently, in-depth interview samples range from 20 to 100 respondents, depending on research question and the researchers' resources.

In-depth interviews have been used to study experience of illness and disability; patient and/or family view of treatment or care giving; health care providers' views of their work; the development and dilemmas in health careers; biographical perspectives on health and illness; and medical issues like adherence, seeking care, use of services, and quality of life (e.g., Conrad 1985, Kleinman 1988, Schneider and Conrad 1983).

2.3 Focus Groups

Since the early 1980s, focus groups have come into fashion as a method for collecting qualitative data,

adapted from marketing research. Focus groups are a collection of people who meet together with the investigator to discuss some topic or issue. Depending on the research topic, the members of the focus group may be already acquainted or unknown to each other, may or may not have direct experience with the topic at hand, and the groups may be of different sizes and composition. Typically, focus groups are small (five to 10 members) and meet from a single to a few occasions with the researcher. The researcher proposes the question or topic and then lets the group discuss it; depending on varying strategies, the leader may guide groups' discussion toward the topic of interest or let the group take its own course. The conversation is usually tape-recorded and then transcribed.

One advantage of focus groups is that they are a very economical method of collecting data. Several well-designed focus groups meeting for a couple of hours each can produce interactive data representing dozens of people. Compared to interviews, focus groups allow for considerable interaction among participants and thus resemble a multifaceted conversation. However, focus groups are artificial occasions, created by the researcher, and thus may not very well reflect everyday life, tend to remain on a superficial level, and are constrained by the group experience.

Focus groups are useful for discovering what a range of views are on different issues, what people's reactions are to certain topics or stimuli (e.g., type of drug or treatment); how people discuss health issues collectively; and to get a sense of the experience related to an illness, care-giving situation, or some other health-related matter (e.g., Kerr et al. 1998).

2.4 Documents

Some qualitative health data comes from sources other than observation, interviews, and focus groups. Most of these data come in the form of some type of document. This can range from governmental or 'official' documents, to organizational memos, to patient records, to news media stories, to personal letters and diaries. They can include pictorial or visual documents but are usually in some form of text. Such documents are ubiquitous to our modern world and are common in health settings and related to health issues.

Document analysis may be used as an adjunct to other methods such as participant-observation or may be the central data of a research inquiry. In some studies the data are collected very systematically, with a rigorous sampling strategy and a tight coding scheme; in other studies, often with limited and scarce data, the data collection is more of a convenience sample meant to illustrate some empirical or conceptual point. In most cases, for textual materials, one of several forms of qualitative content analysis is used to analyze the data. Often the documents can be

analyzed with the same strategies used for other qualitative data.

One advantage of documents is that they already exist and are available if one can get access to them. However, documents were created for other purposes than research and thus may not contain all the information an investigator requires or may represent more the view of the producer than reflect the reality of the situation.

Document analysis has been used to examine the emergence of medical conceptions in the professional literature, the changes in official statements about an illness or treatment, the news media's coverage or depiction of a health problem, an organization's statements about operation or purpose, or the content and presentation in patient records.

3. Qualitative Analysis

Qualitative analysis tends to be inductive rather than deductive. Instead of working from specific hypotheses and with predetermined codes, the researcher codes the data while or after it has been collected. Coding schemes can often be very complicated but are key to the data analysis (see Lofland and Lofland 1995, Strauss 1987).

Once the data are coded, researchers use qualitative analytic strategies such as 'grounded theory' (Glaser and Strauss 1967) to develop a substantive and a conceptual analysis. Grounded theory is a strategy that uses elaborate coding and continuous comparison to develop the analysis, allowing the categories to 'emerge' from close reading and analysis. An important aspect of qualitative analysis is the development of concepts, abstractions from the data that can be used to generalize the findings to other situations or cases. Examples are Glaser and Strauss's (1964) concept of 'awareness contexts' which they developed to understand the different situations and stances around information about dying, and Conrad's (1985) 'self-regulation' as an alternative to the commonly held notion of 'noncompliance.' Qualitative studies rarely claim to develop entire theories but at their best create insightful and useful conceptual understanding of aspects of the empirical world.

The best qualitative health studies enlighten the substantive issue at hand by the application or development of a conceptual analysis. If qualitative studies are to be case studies, the researchers must ask, what is it a case of? This will necessitate a conceptual or theoretical abstraction from the particulars of the case.

4. Contributions of Qualitative Health Research

Qualitative health studies have made important contributions to our knowledge. By insisting that researchers stay close to the data in their analysis and by

emphasizing first-hand data collection, qualitative studies have enlightened areas around health and health care. Qualitative studies are well suited to examining the social context of health care, organizational culture (Anspach 1993), the impacts of technology on patients (Timmermans 1999, Baszanger 1998), bioethics in medical care (Bosk 2000), the experience of illness (Conrad 1987, Anderson and Bury 1988), the functioning of medical organizations (Zussman 1992), and the process of medical education (see Hafferty 2000). Many important studies on patient experience and professional–patient interaction are qualitative (see Conrad 1987, Waitzkin 2000).

For many health issues, qualitative studies provide a unique ‘insider’s approach’ to studying a problem. In their review of ethnographic studies in medical sociology, Charmaz and Olesen (1997) conclude that qualitative studies have contributed in six ways: (a) maintaining a critical focus on the institution of medicine; (b) bringing subjective experience into medical sociology; (c) providing empirical corrections to public, professional, and sociological assumptions about medical care and health and illness; (d) challenging accepted ideas in subfields of medical sociology; (e) deepening other social scientific analyses; and (f) extending the range of medical sociology.

Qualitative research usually stands on its own but can also be used in conjunction with quantitative research; typically, either the quantitative or qualitative research predominates. For example, quantitative research can be used to set the context of a qualitative study or qualitative data can be used as cases to illustrate quantitative findings. True integration of qualitative and quantitative data is achievable although difficult (e.g., Broadhead and Heckathorn 1994).

Qualitative health research is most often of the ethnographic or analytically descriptive form described here. But other varieties have developed, including conversational analysis (e.g., Frankel 1984), narrative research (Kleinman 1988) and biographical reflection (Zola 1982). While these are not discussed separately here, they have also made important contributions to health research.

5. Critiques of Qualitative Health Research

There are several critiques of general qualitative research that also apply to qualitative health research. Since most such studies are of specific sites or nonrandom samples, the question is often raised about how generalizable findings are from the case to the larger population. Generalizability in this sense of sampling is a concept derived from quantitative studies that is often misapplied to qualitative studies. Most qualitative studies attempt to examine social processes that can be revealed by a close investigation and analysis, and it is the processes, not the site or sample, that may be generalizable. Another critique, which

frequently is a self-critique, is that qualitative researchers rarely tend to study ‘up.’ That is, investigators tend to study on their own social level or below, but rarely study the ‘seats of power.’ In health, that means we have many studies of patients, doctors, and health service organizations, but few studies of health insurance organizations, the medical industries, or the high level policy makers. This is in part a problem of access, and, it can be said, true of quantitative social scientific studies as well.

In the late 1980s, a number of scholars advanced the so-called postmodern critique of ethnography, calling into question the authority of the research and researcher and creating what some have called ‘the crisis of representation’ of qualitative research (see Denzin and Lincoln 1994). These critics argued that ethnographies are stories (even ‘fictions’) and narratives rather than authoritative representations of reality. The postmodernist emphasis on the validity of multiple perspectives rather than privileging the authors’ authority and singular truth raises significant questions about data collection, presentation, and validity of research. Some critics even suggest social scientists should abandon the pretense that ethnography adequately represents the ‘real world.’ Postmodernism’s disenchantment with ‘realism’ is not evident in most qualitative health research. Most of the research data are still realist tales (Van Maanen 1988), albeit more reflexive and circumspect than the qualitative research of earlier decades. Qualitative research remains accepted as a social scientific method of investigating social reality.

Having survived challenges from quantitatively oriented disciplines and criticisms from postmodernists, social scientific qualitative health research is by now well-established. New data sources like the Internet, an increasing number of computer-based analytic packages, and adoption of the method by more academic disciplines should allow for continued expansion and development of qualitative health research in the twenty-first century.

See also: Archival Methods; Biographical Methodology; Psychological Perspectives; Case Study: Methods and Analysis; Clinical Assessment: Interview Methods; Clinical Treatment Outcome Research: Control and Comparison Groups; Ethical Dilemmas: Research and Treatment Priorities; Experimenter and Subject Artifacts: Methodology; Field Observational Research in Anthropology and Sociology; Interpretive Methods: Macromethods; Interpretive Methods: Micromethods; Laboratory Experiment: Methodology; Narratives and Accounts, in the Social and Behavioral Sciences; Objectivity of Research: Ethical Aspects; Person-centered Research; Qualitative Methods, History of; Research Subjects, Informed and Implied Consent of; Single-subject Designs: Methodology; Social Survey, History of

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Health Risk Appraisal and Optimistic Bias

1. Importance of Health Risk Perceptions

Perceptions of health risks influence the actions people take to prevent illness and injury, the decisions they make to seek medical care, their choices among treatment options, and their adherence to treatment requirements. Public controversies over the risks that may be created by government and corporate actions are also familiar. During these controversies, scientists and members of the public frequently disagree, demonstrating that laypeople do not passively accept the risk judgments of experts.

These various reasons suggest that it is important to understand how risk perceptions are formed, how accurate they are, and how they influence decisions and behavior. Furthermore, as research continues to identify new risks and 'risk factors' (attributes of individuals or environments that alter a person's likelihood of harm), the need grows to explain this information clearly so that individuals can make better decisions about their health. Such education about risk is the goal of the specialty called 'risk communication.'

2. Defining 'Risk' and 'Risk Perceptions'

Before pursuing this topic it should be mentioned that the term 'risk' is used in several different ways. Sometimes 'risk' is used synonymously with the word 'hazard', denoting a specific undesirable outcome. In this sense, cancer, the common cold, and automobile accidents are all 'risks.' 'Risk' is also used as a synonym